This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141325	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/26/2016 11:09 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2016 Time: 11:09 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF SAINT LUKE MEDICAL CENTER (141325) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	411,923	93,381	61,156	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	152,483	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		55,845		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	564,406	149,226	61,156	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2016 9:53 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1051 WEST SOUTH STREET	PO Box: 747			1.00
2.00	City: KEWANEE	State: IL	Zip Code: 61443	County: HENRY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	OSF SAINT LUKE MEDICAL CENTER	141325	99914	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	OSF SAINT LUKE SWING BED	14Z325	99914		03/19/2003	N	O	N	7.00
8.00	Swing Beds - NF	OSF SAINT LUKE SWING BED	14Z325	99914		03/19/2003	N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FAMILY HEALTH CLINIC	143445	99914		10/01/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2016 9:53 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2016 9:53 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2016 9:53 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	132,534	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2016 9:53 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	149006	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 00131	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	63,906	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	02/01/2015	05/01/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141325	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/25/2016 9:53 am

			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2016 9:53 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	12/23/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2016 9:53 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REBECCA	ROBINSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-624-7644	REBECCA.C.ROBINSON@OSFHEALTHCARE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2016 9:53 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	12/23/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		GOVT REPORTING ANALYST		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2016 9:53 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	28,920.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	28,920.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	3	1,095	1,392.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	30,312.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2016 9:53 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	847	106	1,205			1.00
2.00	HMO and other (see instructions)	72	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	316	0	316			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	46			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,163	106	1,567			7.00
8.00	INTENSIVE CARE UNIT	42	14	58			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	1,205	120	1,625	0.00	163.10	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,915	1,754	13,850	0.00	20.23	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	183.33	27.00
28.00	Observation Bed Days		89	475			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2016 9:53 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	319	51	476	1.00
2.00	HMO and other (see instructions)			26	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	319	51	476	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 141325 Component CCN: 143445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 Date/Time Prepared: 2/25/2016 9:53 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1051 WEST SOUTH STREET	1.00
	City	State	ZIP Code
	1.00	2.00	3.00
2.00	City, State, ZIP Code, County	KEWANEE IL	61443 2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award	Date
		1.00	2.00
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	Clinic			08:00	18:00	08:00 11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN number
		1.00	2.00
14.00	Provider name, CCN number		14.00

		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00

			County			
			4.00			
2.00	City, State, ZIP Code, County		HENRY			2.00

		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
	Facility hours of operations (1)					
11.00	Clinic	18:00	08:00	18:00	08:00	18:00 11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

Provider CCN: 141325
Component CCN: 143445

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-8

Date/Time Prepared:
2/25/2016 9:53 am

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/25/2016 9:53 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.390116	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,797,007	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	3,431,015	5.00
6.00	Medicaid charges	19,281,427	6.00
7.00	Medicaid cost (line 1 times line 6)	7,521,993	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,293,971	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,293,971	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,115,202	214,249	1,329,451	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	435,058	83,582	518,640	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	435,058	83,582	518,640	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,075,902	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	480,746	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,595,156	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	622,296	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,140,936	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,434,907	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,127,537	1,127,537	0	1,127,537	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,555,511	1,555,511	0	1,555,511	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	133,775	2,995,516	3,129,291	0	3,129,291	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,768,724	3,245,924	5,014,648	-60,982	4,953,666	5.00
7.00	00700	OPERATION OF PLANT	297,258	673,788	971,046	0	971,046	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	135,082	135,082	0	135,082	8.00
9.00	00900	HOUSEKEEPING	225,657	37,350	263,007	0	263,007	9.00
10.00	01000	DIETARY	250,884	153,886	404,770	-294,924	109,846	10.00
11.00	01100	CAFETERIA	0	0	0	294,924	294,924	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,926	8,227	40,153	0	40,153	14.00
15.00	01500	PHARMACY	200,325	518,297	718,622	0	718,622	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	172,553	55,181	227,734	0	227,734	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,790,847	329,976	2,120,823	197,052	2,317,875	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	81,062	81,062	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	565,533	653,729	1,219,262	575	1,219,837	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	330,547	143,590	474,137	153,626	627,763	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	870,864	1,376,290	2,247,154	-1,356,869	890,285	54.00
56.00	05600	RADIOISOTOPE	0	0	0	284,081	284,081	56.00
56.01	03630	ULTRA SOUND	0	0	0	155,481	155,481	56.01
57.00	05700	CT SCAN	0	0	0	289,074	289,074	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	548,500	548,500	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	597,459	968,566	1,566,025	-29,724	1,536,301	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	29,724	29,724	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	217,337	217,337	65.00
66.00	06600	PHYSICAL THERAPY	676,275	51,363	727,638	0	727,638	66.00
67.00	06700	OCCUPATIONAL THERAPY	198,508	6,951	205,459	0	205,459	67.00
68.00	06800	SPEECH PATHOLOGY	92,818	3,536	96,354	0	96,354	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	342,196	75,291	417,487	-217,337	200,150	69.01
69.02	03650	VASCULAR LAB	0	0	0	79,733	79,733	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	34,578	34,578	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	551,444	551,444	0	551,444	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,607,386	481,008	2,088,394	-407,857	1,680,537	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	878,018	2,155,403	3,033,421	1,946	3,035,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,031,553	17,303,446	28,334,999	0	28,334,999	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,220	23,627	28,847	0	28,847	190.00
190.01	19001	FOUNDATION	42,098	15,828	57,926	0	57,926	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	11,264	11,264	0	11,264	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,548	14,548	0	14,548	192.00
200.00		TOTAL (SUM OF LINES 118-199)	11,078,871	17,368,713	28,447,584	0	28,447,584	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-115,667	1,011,870		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-58,472	1,497,039		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-358,056	2,771,235		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,310,003	6,263,669		5.00
7.00	00700	OPERATION OF PLANT	0	971,046		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	135,082		8.00
9.00	00900	HOUSEKEEPING	0	263,007		9.00
10.00	01000	DIETARY	0	109,846		10.00
11.00	01100	CAFETERIA	-130,071	164,853		11.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	40,153		14.00
15.00	01500	PHARMACY	0	718,622		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,191	221,543		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-835,816	1,482,059		30.00
31.00	03100	INTENSIVE CARE UNIT	0	81,062		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-35,153	1,184,684		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-579,873	47,890		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	890,285		54.00
56.00	05600	RADIOISOTOPE	0	284,081		56.00
56.01	03630	ULTRA SOUND	0	155,481		56.01
57.00	05700	CT SCAN	0	289,074		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	548,500		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-26,575	1,509,726		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	29,724		62.00
65.00	06500	RESPIRATORY THERAPY	3,859	221,196		65.00
66.00	06600	PHYSICAL THERAPY	-9,552	718,086		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	205,459		67.00
68.00	06800	SPEECH PATHOLOGY	0	96,354		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	200,150		69.01
69.02	03650	VASCULAR LAB	0	79,733		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,578		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-9,210	542,234		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-4,249	1,676,288		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	-1,507,741	1,527,626		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,362,764	25,972,235		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,847		190.00
190.01	19001	FOUNDATION	0	57,926		190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	11,264		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,548		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,362,764	26,084,820		200.00

RECLASSIFICATIONS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/25/2016 9:53 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	182,799	112,125		1.00
	0		182,799	112,125		
	D - BLOOD COSTS					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	5,407	24,317		1.00
	0		5,407	24,317		
	E - RESPIRATORY THERAPY					
1.00	RESPIRATORY THERAPY	65.00	178,141	39,196		1.00
	0		178,141	39,196		
	F - RADIOLOGY SERVICES					
1.00	RADIOISOTOPE	56.00	0	284,081		1.00
2.00	CT SCAN	57.00	215,173	73,901		2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	548,500		3.00
4.00	VASCULAR LAB	69.02	79,733	0		4.00
5.00	ULTRA SOUND	56.01	155,481	0		5.00
	0		450,387	906,482		
	I - CASE MANAGER/DIR NRS					
1.00	ADULTS & PEDIATRICS	30.00	59,788	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	343	0		2.00
3.00	EMERGENCY	91.00	851	0		3.00
	0		60,982	0		
	J - SURGEON RHC					
1.00	ADULTS & PEDIATRICS	30.00	203,958	0		1.00
2.00	ANESTHESIOLOGY	53.00	119,785	0		2.00
	0		323,743	0		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	34,578		1.00
	0		0	34,578		
	L - ICU COSTS					
1.00	INTENSIVE CARE UNIT	31.00	68,160	12,559		1.00
	0		68,160	12,559		
	M - UROLOGY IN RHC					
1.00	ADULTS & PEDIATRICS	30.00	0	14,025		1.00
2.00	OPERATING ROOM	50.00	0	35,153		2.00
3.00	ANESTHESIOLOGY	53.00	0	7,552		3.00
	0		0	56,730		
	N - ORTHI IN RHC					
1.00	ANESTHESIOLOGY	53.00	0	26,289		1.00
2.00	EMERGENCY	91.00	0	1,095		2.00
	TOTALS		0	27,384		
500.00	Grand Total: Increases		1,269,619	1,213,371		500.00

RECLASSIFICATIONS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/25/2016 9:53 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	C - CAFETERIA					
1.00	DIETARY	10.00	182,799	112,125	0	1.00
	0		182,799	112,125		
	D - BLOOD COSTS					
1.00	LABORATORY	60.00	5,407	24,317	0	1.00
	0		5,407	24,317		
	E - RESPIRATORY THERAPY					
1.00	CARDIOPULMONARY	69.01	178,141	39,196	0	1.00
	0		178,141	39,196		
	F - RADIOLOGY SERVICES					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	450,387	906,482	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	0		450,387	906,482		
	I - CASE MANAGER/DIR NRS					
1.00	ADMINISTRATIVE & GENERAL	5.00	60,982	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		60,982	0		
	J - SURGEON RHC					
1.00	RURAL HEALTH CLINIC	88.00	323,743	0	0	1.00
2.00		0.00	0	0	0	2.00
	0		323,743	0		
	K - IMPLANTABLE DEVICES					
1.00	OPERATING ROOM	50.00	0	34,578	0	1.00
	0		0	34,578		
	L - ICU COSTS					
1.00	ADULTS & PEDIATRICS	30.00	68,160	12,559	0	1.00
	0		68,160	12,559		
	M - UROLOGY IN RHC					
1.00	RURAL HEALTH CLINIC	88.00	0	56,730	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		0	56,730		
	N - ORTHI IN RHC					
1.00	RURAL HEALTH CLINIC	88.00	0	27,384	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	27,384		
500.00	Grand Total: Decreases		1,269,619	1,213,371		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2016 9:53 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	588,318	0	0	0	0	1.00
2.00	Land Improvements	854,467	0	0	0	0	2.00
3.00	Buildings and Fixtures	20,198,895	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,391,600	259,734	0	259,734	1,114,528	6.00
7.00	HIT designated Assets	3,139,030	63,906	0	63,906	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,172,310	323,640	0	323,640	1,114,528	8.00
9.00	Reconciling Items	5,781	98,593	0	98,593	0	9.00
10.00	Total (line 8 minus line 9)	46,166,529	225,047	0	225,047	1,114,528	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	588,318	0	1.00
2.00	Land Improvements	854,467	0	2.00
3.00	Buildings and Fixtures	20,198,895	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	20,536,806	0	6.00
7.00	HIT designated Assets	3,202,936	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,381,422	0	8.00
9.00	Reconciling Items	104,374	0	9.00
10.00	Total (line 8 minus line 9)	45,277,048	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2016 9:53 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	564,031	0	563,506	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,555,511	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,119,542	0	563,506	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,127,537	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,555,511	2.00
3.00	Total (sum of lines 1-2)	0	2,683,048	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2016 9:53 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,053,362	0	21,053,362	0.471111	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,635,368	0	23,635,368	0.528889	0	2.00
3.00	Total (sum of lines 1-2)	44,688,730	0	44,688,730	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,017,553	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,497,039	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,514,592	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-5,683	0	0	0	1,011,870	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,497,039	2.00
3.00	Total (sum of lines 1-2)	-5,683	0	0	0	2,508,909	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/25/2016 9:53 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-563,506	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,423,422			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,823,247			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-130,071	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,191	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-432,886	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MAT MGMT OPERATIONS	B	-478	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	HEALTH PROFESSIONAL ED REVENUE	B	-20,362	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/25/2016 9:53 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	OTHER REVENUE	B	-10,630	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER REVENUE - PT	B	-9,552	PHYSICAL THERAPY	66.00	0	33.03
33.04	OTHER REVENUE - PHARM	B	-9,210	DRUGS CHARGED TO PATIENTS	73.00	0	33.04
33.05	OTHER REVENUE - MED STAFF	B	-5,161	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06			0		0.00	0	33.06
33.07			0		0.00	0	33.07
33.08	RENTAL/LEASE EQUPMENT	B	3,859	RESPIRATORY THERAPY	65.00	0	33.08
33.09	PROVIDER TAX	A	-757,520	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PATIENT PHONE - SALARIES	A	-1,427	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PATIENT PHONE - BENEF	A	-379	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PATIENT PHONE OTHER	A	-968	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	PATIENT PHONE DEPREC	A	-248	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.13
33.14	LOBBYING	A	-17,539	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	IMPAIRMENT OF ASSETS	A	413,833	CAP REL COSTS-BLDG & FIXT	1.00	9	33.15
33.16	IMPAIRMENT OF ASSETS	A	-38,200	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	LOSS ON EXT OF DEBT	A	-5,683	CAP REL COSTS-BLDG & FIXT	1.00	11	33.17
33.18	PATEINT TV	A	-1,087	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.18
33.19	MARKETING SALARY	A	-44,941	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	MARKETING BENEFITS	A	-11,927	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	MARKETING OTHER EXPENSE	A	-114,107	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	PHYSICIAN RECRUITMENT	A	-4,249	RURAL HEALTH CLINIC	88.00	0	33.22
33.23	PHYSICIAN RECRUITMENT	A	-25,000	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	PATIENT TRANSPORTATION	A	-135,489	EMERGENCY	91.00	0	33.24
33.25	REAL ESTATE TAXES	A	-61,473	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	CRNA - SALARY	A	-330,547	ANESTHESIOLOGY	53.00	0	33.26
33.27	CRNA - BENEFITS	A	-87,719	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.27
33.28	CRNA - OTHER EXPENSE	A	-95,700	ANESTHESIOLOGY	53.00	0	33.28
33.29	PAYROLL/PHYSICIAN - MED/SURG BENEFIT	A	-172,109	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.29
33.30	PAYROLL/PHYSICIAN - FHC BENEFITS	A	-54,131	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.30
33.31	PAYROLL/PHYSICIAN - FHC BENEFITS	A	-31,791	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.31
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,362,764				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2016 9:53 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	90,616	50,927	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	413,949	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST (OPERATING)	930,693	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	A&G HO MANAGEMENT	2,433,720	994,804	4.00
4.01	30.00	ADULTS & PEDIATRICS	SFI - ETS EQUIP RENTAL	413	413	4.01
4.02	7.00	OPERATION OF PLANT	SFI - BIO MED	362	362	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	SFI - MOBILE MRI	548,500	548,500	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	MINISTRY FEES	5,740	5,740	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,423,993	1,600,746	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	OSF HEALTHCARE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141325	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/25/2016 9:53 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	39,689	9		1.00
2.00	413,949	9		2.00
3.00	930,693	0		3.00
4.00	1,438,916	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	2,823,247			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2016 9:53 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,039,774	835,816	0	0	0	1.00
2.00	50.00	OPERATING ROOM	35,153	35,153	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	153,626	153,626	0	0	0	3.00
4.00	60.00	LABORATORY	26,575	26,575	0	0	0	4.00
5.00	91.00	EMERGENCY	1,633,425	1,372,252	261,173	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,888,553	2,423,422	261,173		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	835,816		1.00
2.00	50.00	OPERATING ROOM	0	0	0	35,153		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	153,626		3.00
4.00	60.00	LABORATORY	0	0	0	26,575		4.00
5.00	91.00	EMERGENCY	0	0	0	1,372,252		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,423,422		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,011,870	1,011,870				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,497,039		1,497,039			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,771,235	4,566	987	2,776,788		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,263,669	160,261	457,441	433,258	7,314,629	5.00
7.00	00700	OPERATION OF PLANT	971,046	85,342	440,830	75,415	1,572,633	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	135,082	4,346	0	0	139,428	8.00
9.00	00900	HOUSEKEEPING	263,007	8,356	924	57,250	329,537	9.00
10.00	01000	DIETARY	109,846	23,262	10,555	17,273	160,936	10.00
11.00	01100	CAFETERIA	164,853	7,936	0	46,376	219,165	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,023	0	0	3,023	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,153	0	11,062	8,100	59,315	14.00
15.00	01500	PHARMACY	718,622	14,287	5,835	50,823	789,567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	221,543	19,766	3,763	43,777	288,849	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,482,059	189,527	60,790	503,957	2,236,333	30.00
31.00	03100	INTENSIVE CARE UNIT	81,062	26,789	4,401	17,379	129,631	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,184,684	100,616	161,338	143,477	1,590,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	47,890	1,417	46,846	114,250	210,403	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	890,285	48,634	122,912	106,676	1,168,507	54.00
56.00	05600	RADIOISOTOPE	284,081	2,834	0	0	286,915	56.00
56.01	03630	ULTRA SOUND	155,481	2,456	0	39,446	197,383	56.01
57.00	05700	CT SCAN	289,074	3,968	0	54,590	347,632	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	548,500	8,125	0	0	556,625	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,509,726	20,743	34,974	150,205	1,715,648	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	29,724	1,890	0	1,372	32,986	62.00
65.00	06500	RESPIRATORY THERAPY	221,196	5,857	0	45,195	272,248	65.00
66.00	06600	PHYSICAL THERAPY	718,086	35,355	18,865	171,572	943,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,459	3,212	759	50,362	259,792	67.00
68.00	06800	SPEECH PATHOLOGY	96,354	1,134	1,102	23,548	122,138	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	200,150	17,467	74,522	41,621	333,760	69.01
69.02	03650	VASCULAR LAB	79,733	1,134	0	20,228	101,095	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,578	0	0	0	34,578	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	542,234	0	0	0	542,234	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,676,288	98,506	3,020	325,663	2,103,477	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,527,626	74,142	31,517	222,971	1,856,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,972,235	974,951	1,492,443	2,764,784	25,918,716	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,847	9,605	290	1,324	40,066	190.00
190.01	19001	FOUNDATION	57,926	0	3,671	10,680	72,277	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	11,264	0	0	0	11,264	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,548	27,314	635	0	42,497	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	26,084,820	1,011,870	1,497,039	2,776,788	26,084,820	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,314,629					5.00
7.00	00700	OPERATION OF PLANT	612,846	2,185,479				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,334	12,469	206,231			8.00
9.00	00900	HOUSEKEEPING	128,419	23,975	29,566	511,497		9.00
10.00	01000	DIETARY	62,716	66,743	64	3,978	294,437	10.00
11.00	01100	CAFETERIA	85,407	22,770	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,178	8,674	0	2,303	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,115	0	714	7,956	0	14.00
15.00	01500	PHARMACY	307,690	40,992	0	9,422	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,563	56,714	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	871,485	543,793	56,317	218,585	283,231	30.00
31.00	03100	INTENSIVE CARE UNIT	50,516	76,863	1,307	5,234	11,206	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	619,658	288,689	19,510	61,974	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	81,993	4,066	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	455,360	139,540	12,205	45,853	0	54.00
56.00	05600	RADIOISOTOPE	111,809	8,132	0	0	0	56.00
56.01	03630	ULTRA SOUND	76,919	7,048	0	0	0	56.01
57.00	05700	CT SCAN	135,470	11,385	0	5,025	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	216,913	23,312	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	668,578	59,515	0	24,915	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	12,854	5,421	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	106,093	16,806	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	367,824	101,440	13,440	20,100	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,239	9,216	0	5,653	0	67.00
68.00	06800	SPEECH PATHOLOGY	47,596	3,253	0	5,862	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	130,064	50,118	10,890	4,397	0	69.01
69.02	03650	VASCULAR LAB	39,396	3,253	0	4,187	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,475	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	211,305	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	819,712	282,635	0	24,706	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	723,372	212,729	62,218	49,203	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,249,899	2,079,551	206,231	499,353	294,437	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,613	27,559	0	0	0	190.00
190.01	19001	FOUNDATION	28,166	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	4,390	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,561	78,369	0	12,144	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,314,629	2,185,479	206,231	511,497	294,437	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	327,342					11.00
13.00	01300	NURSING ADMINISTRATION	0	15,178				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,066	0	93,166			14.00
15.00	01500	PHARMACY	7,815	670	0	1,156,156		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,326	0	0	0	471,452	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,471	4,674	1,011	0	14,527	30.00
31.00	03100	INTENSIVE CARE UNIT	2,358	202	53	0	1,497	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,532	2,104	78,215	0	54,637	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	16,026	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,975	1,713	0	0	29,843	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	6,586	56.00
56.01	03630	ULTRA SOUND	6,729	577	0	0	10,842	56.01
57.00	05700	CT SCAN	7,789	668	0	0	57,642	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	19,148	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	33,116	0	0	0	100,759	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	291	0	0	0	876	62.00
65.00	06500	RESPIRATORY THERAPY	9,166	786	0	0	15,299	65.00
66.00	06600	PHYSICAL THERAPY	29,698	0	0	0	16,480	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,782	0	0	0	4,165	67.00
68.00	06800	SPEECH PATHOLOGY	4,080	0	0	0	773	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	8,451	725	505	0	14,089	69.01
69.02	03650	VASCULAR LAB	4,769	0	0	0	2,734	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,156,156	25,499	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	53,594	0	7,582	0	19,585	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	35,659	3,059	5,800	0	60,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	324,667	15,178	93,166	1,156,156	471,452	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	450	0	0	0	0	190.00
190.01	19001	FOUNDATION	2,225	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	327,342	15,178	93,166	1,156,156	471,452	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,284,427	0	4,284,427		30.00
31.00	03100	INTENSIVE CARE UNIT	0	278,867	0	278,867		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,739,434	0	2,739,434		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	312,488	0	312,488		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,872,996	0	1,872,996		54.00
56.00	05600	RADIOISOTOPE	0	413,442	0	413,442		56.00
56.01	03630	ULTRA SOUND	0	299,498	0	299,498		56.01
57.00	05700	CT SCAN	0	565,611	0	565,611		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	815,998	0	815,998		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	2,602,531	0	2,602,531		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	52,428	0	52,428		62.00
65.00	06500	RESPIRATORY THERAPY	0	420,398	0	420,398		65.00
66.00	06600	PHYSICAL THERAPY	0	1,492,860	0	1,492,860		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	386,847	0	386,847		67.00
68.00	06800	SPEECH PATHOLOGY	0	183,702	0	183,702		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	552,999	0	552,999		69.01
69.02	03650	VASCULAR LAB	0	155,434	0	155,434		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,458	0	48,458		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,935,194	0	1,935,194		73.00
73.01	03480	ONCOLOGY	0	0	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,311,291	0	3,311,291		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	0	3,008,336	0	3,008,336		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	25,733,239	0	25,733,239		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	83,688	0	83,688		190.00
190.01	19001	FOUNDATION	0	102,668	0	102,668		190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	15,654	0	15,654		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	149,571	0	149,571		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	26,084,820	0	26,084,820		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,566	987	5,553	5,553	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	160,261	457,441	617,702	866	5.00
7.00	00700	OPERATION OF PLANT	0	85,342	440,830	526,172	151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,346	0	4,346	0	8.00
9.00	00900	HOUSEKEEPING	0	8,356	924	9,280	114	9.00
10.00	01000	DIETARY	0	23,262	10,555	33,817	35	10.00
11.00	01100	CAFETERIA	0	7,936	0	7,936	93	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,023	0	3,023	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	11,062	11,062	16	14.00
15.00	01500	PHARMACY	0	14,287	5,835	20,122	102	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,766	3,763	23,529	87	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	189,527	60,790	250,317	1,010	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,789	4,401	31,190	35	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	100,616	161,338	261,954	287	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,417	46,846	48,263	228	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,634	122,912	171,546	213	54.00
56.00	05600	RADIOISOTOPE	0	2,834	0	2,834	0	56.00
56.01	03630	ULTRA SOUND	0	2,456	0	2,456	79	56.01
57.00	05700	CT SCAN	0	3,968	0	3,968	109	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,125	0	8,125	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	20,743	34,974	55,717	300	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,890	0	1,890	3	62.00
65.00	06500	RESPIRATORY THERAPY	0	5,857	0	5,857	90	65.00
66.00	06600	PHYSICAL THERAPY	0	35,355	18,865	54,220	343	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,212	759	3,971	101	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,134	1,102	2,236	47	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	17,467	74,522	91,989	83	69.01
69.02	03650	VASCULAR LAB	0	1,134	0	1,134	40	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	98,506	3,020	101,526	651	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	74,142	31,517	105,659	446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	974,951	1,492,443	2,467,394	5,529	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,605	290	9,895	3	190.00
190.01	19001	FOUNDATION	0	0	3,671	3,671	21	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,314	635	27,949	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,011,870	1,497,039	2,508,909	5,553	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	618,568					5.00
7.00	00700	OPERATION OF PLANT	51,826	578,149				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,595	3,299	12,240			8.00
9.00	00900	HOUSEKEEPING	10,860	6,342	1,755	28,351		9.00
10.00	01000	DIETARY	5,304	17,656	4	220	57,036	10.00
11.00	01100	CAFETERIA	7,223	6,024	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	100	2,295	0	128	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,955	0	42	441	0	14.00
15.00	01500	PHARMACY	26,020	10,844	0	522	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,519	15,003	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	73,695	143,856	3,342	12,117	54,865	30.00
31.00	03100	INTENSIVE CARE UNIT	4,272	20,333	78	290	2,171	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,402	76,370	1,158	3,435	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	6,934	1,076	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,508	36,914	724	2,541	0	54.00
56.00	05600	RADIOISOTOPE	9,455	2,151	0	0	0	56.00
56.01	03630	ULTRA SOUND	6,505	1,864	0	0	0	56.01
57.00	05700	CT SCAN	11,456	3,012	0	279	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,344	6,167	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	56,539	15,744	0	1,381	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,087	1,434	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	8,972	4,446	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	31,105	26,835	798	1,114	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,561	2,438	0	313	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,025	861	0	325	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	10,999	13,258	646	244	0	69.01
69.02	03650	VASCULAR LAB	3,332	861	0	232	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,140	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,869	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,320	74,768	0	1,369	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	61,173	56,276	3,693	2,727	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	613,095	550,127	12,240	27,678	57,036	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,320	7,290	0	0	0	190.00
190.01	19001	FOUNDATION	2,382	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	371	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,400	20,732	0	673	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	618,568	578,149	12,240	28,351	57,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	21,276					11.00
13.00	01300	NURSING ADMINISTRATION	0	5,546				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	134	0	13,650			14.00
15.00	01500	PHARMACY	508	245	0	58,363		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	866	0	0	0	49,004	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,543	1,707	148	0	1,510	30.00
31.00	03100	INTENSIVE CARE UNIT	153	74	8	0	156	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,594	769	11,459	0	5,680	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,666	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,298	626	0	0	3,103	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	685	56.00
56.01	03630	ULTRA SOUND	437	211	0	0	1,127	56.01
57.00	05700	CT SCAN	506	244	0	0	5,992	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,991	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,152	0	0	0	10,467	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	19	0	0	0	91	62.00
65.00	06500	RESPIRATORY THERAPY	596	287	0	0	1,590	65.00
66.00	06600	PHYSICAL THERAPY	1,930	0	0	0	1,713	66.00
67.00	06700	OCCUPATIONAL THERAPY	441	0	0	0	433	67.00
68.00	06800	SPEECH PATHOLOGY	265	0	0	0	80	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	549	265	74	0	1,465	69.01
69.02	03650	VASCULAR LAB	310	0	0	0	284	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	42	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	58,363	2,651	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,483	0	1,111	0	2,036	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,318	1,118	850	0	6,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,102	5,546	13,650	58,363	49,004	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29	0	0	0	0	190.00
190.01	19001	FOUNDATION	145	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,276	5,546	13,650	58,363	49,004	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	546,110	0	546,110		30.00
31.00	03100	INTENSIVE CARE UNIT	0	58,760	0	58,760		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	415,108	0	415,108		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	58,167	0	58,167		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	255,473	0	255,473		54.00
56.00	05600	RADIOISOTOPE	0	15,125	0	15,125		56.00
56.01	03630	ULTRA SOUND	0	12,679	0	12,679		56.01
57.00	05700	CT SCAN	0	25,566	0	25,566		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	34,627	0	34,627		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	142,300	0	142,300		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,524	0	4,524		62.00
65.00	06500	RESPIRATORY THERAPY	0	21,838	0	21,838		65.00
66.00	06600	PHYSICAL THERAPY	0	118,058	0	118,058		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,258	0	16,258		67.00
68.00	06800	SPEECH PATHOLOGY	0	7,839	0	7,839		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	119,572	0	119,572		69.01
69.02	03650	VASCULAR LAB	0	6,193	0	6,193		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,182	0	1,182		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	78,883	0	78,883		73.00
73.01	03480	ONCOLOGY	0	0	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	254,264	0	254,264		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	0	240,502	0	240,502		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,433,028	0	2,433,028		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,537	0	18,537		190.00
190.01	19001	FOUNDATION	0	6,219	0	6,219		190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	371	0	371		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,754	0	50,754		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	2,508,909	0	2,508,909		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	96,394					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,986,990				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	435	1,310	10,945,096			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,267	607,152	1,707,742	-7,314,629	18,770,191	5.00
7.00	00700	OPERATION OF PLANT	8,130	585,104	297,258	0	1,572,633	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	0	0	0	139,428	8.00
9.00	00900	HOUSEKEEPING	796	1,227	225,657	0	329,537	9.00
10.00	01000	DIETARY	2,216	14,009	68,085	0	160,936	10.00
11.00	01100	CAFETERIA	756	0	182,799	0	219,165	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	0	0	3,023	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,683	31,926	0	59,315	14.00
15.00	01500	PHARMACY	1,361	7,745	200,325	0	789,567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	4,995	172,553	0	288,849	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,055	80,685	1,986,433	0	2,236,333	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	5,842	68,503	0	129,631	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,585	214,141	565,533	0	1,590,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	62,178	450,332	0	210,403	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,633	163,138	420,477	0	1,168,507	54.00
56.00	05600	RADIOISOTOPE	270	0	0	0	286,915	56.00
56.01	03630	ULTRA SOUND	234	0	155,481	0	197,383	56.01
57.00	05700	CT SCAN	378	0	215,173	0	347,632	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	556,625	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	46,420	592,052	0	1,715,648	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	5,407	0	32,986	62.00
65.00	06500	RESPIRATORY THERAPY	558	0	178,141	0	272,248	65.00
66.00	06600	PHYSICAL THERAPY	3,368	25,039	676,275	0	943,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	1,007	198,508	0	259,792	67.00
68.00	06800	SPEECH PATHOLOGY	108	1,462	92,818	0	122,138	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,664	98,911	164,055	0	333,760	69.01
69.02	03650	VASCULAR LAB	108	0	79,733	0	101,095	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	34,578	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	542,234	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,384	4,009	1,283,643	0	2,103,477	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	41,832	878,869	0	1,856,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,877	1,980,889	10,897,778	-7,314,629	18,604,087	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	385	5,220	0	40,066	190.00
190.01	19001	FOUNDATION	0	4,873	42,098	0	72,277	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	11,264	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	843	0	0	42,497	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,011,870	1,497,039	2,776,788		7,314,629	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.497230	0.753421	0.253702		0.389694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,553		618,568	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000507		0.032955	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	72,562					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	25,718				8.00
9.00	00900	HOUSEKEEPING	796	3,687	2,443			9.00
10.00	01000	DIETARY	2,216	8	19	1,629		10.00
11.00	01100	CAFETERIA	756	0	0	0	12,356	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	11	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	89	38	0	78	14.00
15.00	01500	PHARMACY	1,361	0	45	0	295	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	0	0	0	503	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,055	7,023	1,044	1,567	2,056	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	163	25	62	89	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,585	2,433	296	0	926	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,633	1,522	219	0	754	54.00
56.00	05600	RADIOISOTOPE	270	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	234	0	0	0	254	56.01
57.00	05700	CT SCAN	378	0	24	0	294	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	0	119	0	1,250	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	0	0	11	62.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	346	65.00
66.00	06600	PHYSICAL THERAPY	3,368	1,676	96	0	1,121	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	27	0	256	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	28	0	154	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,664	1,358	21	0	319	69.01
69.02	03650	VASCULAR LAB	108	0	20	0	180	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,384	0	118	0	2,023	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	7,759	235	0	1,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,045	25,718	2,385	1,629	12,255	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	0	0	0	17	190.00
190.01	19001	FOUNDATION	0	0	0	0	84	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	58	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,185,479	206,231	511,497	294,437	327,342	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.118781	8.018936	209.372493	180.747084	26.492554	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	578,149	12,240	28,351	57,036	21,276	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.967655	0.475931	11.604994	35.012891	1.721916	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/25/2016 9:53 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	6,679					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,502				14.00
15.00	01500	PHARMACY	295	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	65,963,039		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,056	38	0	2,032,571	0	30.00
31.00	03100	INTENSIVE CARE UNIT	89	2	0	209,500	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	926	2,940	0	7,644,791	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,242,302	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754	0	0	4,175,659	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	921,511	0	56.00
56.01	03630	ULTRA SOUND	254	0	0	1,516,944	0	56.01
57.00	05700	CT SCAN	294	0	0	8,065,221	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,679,100	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	14,096,050	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	122,573	0	62.00
65.00	06500	RESPIRATORY THERAPY	346	0	0	2,140,630	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,305,894	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	582,755	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	108,132	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	319	19	0	1,971,365	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	382,573	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	56,655	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	3,567,815	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	285	0	2,740,262	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,346	218	0	8,400,736	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,679	3,502	100	65,963,039	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	15,178	93,166	1,156,156	471,452	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.272496	26.603655	11,561.560000	0.007147	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,546	13,650	58,363	49,004	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.830364	3.897773	583.630000	0.000743	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,284,427		4,284,427	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	278,867		278,867	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,739,434		2,739,434	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	312,488		312,488	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,872,996		1,872,996	0	0	54.00
56.00	05600	RADIOISOTOPE	413,442		413,442	0	0	56.00
56.01	03630	ULTRA SOUND	299,498		299,498	0	0	56.01
57.00	05700	CT SCAN	565,611		565,611	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	815,998		815,998	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,602,531		2,602,531	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	52,428		52,428	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	420,398	0	420,398	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,492,860	0	1,492,860	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	386,847	0	386,847	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	183,702	0	183,702	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	552,999		552,999	0	0	69.01
69.02	03650	VASCULAR LAB	155,434		155,434	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,458		48,458	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,935,194		1,935,194	0	0	73.00
73.01	03480	ONCOLOGY	0		0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,311,291		3,311,291	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	3,008,336		3,008,336	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,018,015		1,018,015		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,751,254	0	26,751,254	0	0	200.00
201.00		Less Observation Beds	1,018,015		1,018,015		0	201.00
202.00		Total (see instructions)	25,733,239	0	25,733,239	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,514,926		1,514,926			30.00
31.00	03100	INTENSIVE CARE UNIT	209,500		209,500			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	590,273	7,054,518	7,644,791	0.358340	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	321,798	1,920,504	2,242,302	0.139360	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,993	4,065,666	4,175,659	0.448551	0.000000	54.00
56.00	05600	RADIOISOTOPE	34,064	887,447	921,511	0.448657	0.000000	56.00
56.01	03630	ULTRA SOUND	22,605	1,494,339	1,516,944	0.197435	0.000000	56.01
57.00	05700	CT SCAN	102,356	7,962,865	8,065,221	0.070130	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,712	2,650,388	2,679,100	0.304579	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	791,338	13,304,712	14,096,050	0.184628	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	27,272	95,301	122,573	0.427729	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,076,030	1,064,600	2,140,630	0.196390	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	295,416	2,010,478	2,305,894	0.647411	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	190,682	392,073	582,755	0.663824	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	11,335	96,797	108,132	1.698868	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	183,053	1,788,312	1,971,365	0.280516	0.000000	69.01
69.02	03650	VASCULAR LAB	11,022	371,551	382,573	0.406286	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	56,655	56,655	0.855317	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	677,210	2,890,605	3,567,815	0.542403	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,740,262	2,740,262			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	282,705	8,118,031	8,400,736	0.358104	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,091	515,554	517,645	1.966628	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,482,381	59,480,658	65,963,039			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,482,381	59,480,658	65,963,039			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	03630	ULTRA SOUND	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160	CARDIOPULMONARY	0.000000		69.01
69.02	03650	VASCULAR LAB	0.000000		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/25/2016 9:53 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,284,427		4,284,427	0	4,284,427	30.00
31.00	03100	INTENSIVE CARE UNIT	278,867		278,867	0	278,867	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,739,434		2,739,434	0	2,739,434	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	312,488		312,488	0	312,488	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,872,996		1,872,996	0	1,872,996	54.00
56.00	05600	RADIOISOTOPE	413,442		413,442	0	413,442	56.00
56.01	03630	ULTRA SOUND	299,498		299,498	0	299,498	56.01
57.00	05700	CT SCAN	565,611		565,611	0	565,611	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	815,998		815,998	0	815,998	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,602,531		2,602,531	0	2,602,531	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	52,428		52,428	0	52,428	62.00
65.00	06500	RESPIRATORY THERAPY	420,398	0	420,398	0	420,398	65.00
66.00	06600	PHYSICAL THERAPY	1,492,860	0	1,492,860	0	1,492,860	66.00
67.00	06700	OCCUPATIONAL THERAPY	386,847	0	386,847	0	386,847	67.00
68.00	06800	SPEECH PATHOLOGY	183,702	0	183,702	0	183,702	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	552,999		552,999	0	552,999	69.01
69.02	03650	VASCULAR LAB	155,434		155,434	0	155,434	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,458		48,458	0	48,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,935,194		1,935,194	0	1,935,194	73.00
73.01	03480	ONCOLOGY	0		0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,311,291		3,311,291	0	3,311,291	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	3,008,336		3,008,336	0	3,008,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,018,015		1,018,015		1,018,015	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,751,254	0	26,751,254	0	26,751,254	200.00
201.00		Less Observation Beds	1,018,015		1,018,015		1,018,015	201.00
202.00		Total (see instructions)	25,733,239	0	25,733,239	0	25,733,239	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/25/2016 9:53 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,514,926		1,514,926			30.00
31.00	03100	INTENSIVE CARE UNIT	209,500		209,500			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	590,273	7,054,518	7,644,791	0.358340	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	321,798	1,920,504	2,242,302	0.139360	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,993	4,065,666	4,175,659	0.448551	0.000000	54.00
56.00	05600	RADIOISOTOPE	34,064	887,447	921,511	0.448657	0.000000	56.00
56.01	03630	ULTRA SOUND	22,605	1,494,339	1,516,944	0.197435	0.000000	56.01
57.00	05700	CT SCAN	102,356	7,962,865	8,065,221	0.070130	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,712	2,650,388	2,679,100	0.304579	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	791,338	13,304,712	14,096,050	0.184628	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	27,272	95,301	122,573	0.427729	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,076,030	1,064,600	2,140,630	0.196390	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	295,416	2,010,478	2,305,894	0.647411	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	190,682	392,073	582,755	0.663824	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	11,335	96,797	108,132	1.698868	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	183,053	1,788,312	1,971,365	0.280516	0.000000	69.01
69.02	03650	VASCULAR LAB	11,022	371,551	382,573	0.406286	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	56,655	56,655	0.855317	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	677,210	2,890,605	3,567,815	0.542403	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,740,262	2,740,262	1.208385	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	282,705	8,118,031	8,400,736	0.358104	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,091	515,554	517,645	1.966628	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,482,381	59,480,658	65,963,039			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,482,381	59,480,658	65,963,039			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/25/2016 9:53 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
56.01	03630	ULTRA SOUND	0.000000	56.01
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0.000000	69.01
69.02	03650	VASCULAR LAB	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	03480	ONCOLOGY	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	415,108	7,644,791	0.054299	249,325	13,538	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	58,167	2,242,302	0.025941	87,486	2,269	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,473	4,175,659	0.061181	61,464	3,760	54.00
56.00	05600	RADIOISOTOPE	15,125	921,511	0.016413	16,982	279	56.00
56.01	03630	ULTRA SOUND	12,679	1,516,944	0.008358	14,809	124	56.01
57.00	05700	CT SCAN	25,566	8,065,221	0.003170	60,419	192	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	34,627	2,679,100	0.012925	20,289	262	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	142,300	14,096,050	0.010095	502,665	5,074	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,524	122,573	0.036909	23,297	860	62.00
65.00	06500	RESPIRATORY THERAPY	21,838	2,140,630	0.010202	802,186	8,184	65.00
66.00	06600	PHYSICAL THERAPY	118,058	2,305,894	0.051198	118,446	6,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,258	582,755	0.027899	62,244	1,737	67.00
68.00	06800	SPEECH PATHOLOGY	7,839	108,132	0.072495	8,676	629	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	119,572	1,971,365	0.060654	26,609	1,614	69.01
69.02	03650	VASCULAR LAB	6,193	382,573	0.016188	7,517	122	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,182	56,655	0.020863	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,883	3,567,815	0.022110	376,040	8,314	73.00
73.01	03480	ONCOLOGY	0	0	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	254,264	2,740,262	0.092788	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	240,502	8,400,736	0.028629	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	154,406	517,645	0.298286	0	0	92.00
200.00		Total (lines 50-199)	1,982,564	64,238,613		2,438,454	53,022	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,644,791	0.000000	0.000000	249,325	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,242,302	0.000000	0.000000	87,486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,175,659	0.000000	0.000000	61,464	54.00
56.00	05600	RADIOISOTOPE	0	921,511	0.000000	0.000000	16,982	56.00
56.01	03630	ULTRA SOUND	0	1,516,944	0.000000	0.000000	14,809	56.01
57.00	05700	CT SCAN	0	8,065,221	0.000000	0.000000	60,419	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,679,100	0.000000	0.000000	20,289	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	14,096,050	0.000000	0.000000	502,665	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	122,573	0.000000	0.000000	23,297	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,140,630	0.000000	0.000000	802,186	65.00
66.00	06600	PHYSICAL THERAPY	0	2,305,894	0.000000	0.000000	118,446	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	582,755	0.000000	0.000000	62,244	67.00
68.00	06800	SPEECH PATHOLOGY	0	108,132	0.000000	0.000000	8,676	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,971,365	0.000000	0.000000	26,609	69.01
69.02	03650	VASCULAR LAB	0	382,573	0.000000	0.000000	7,517	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	56,655	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,567,815	0.000000	0.000000	376,040	73.00
73.01	03480	ONCOLOGY	0	0	0.000000	0.000000	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,740,262	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	8,400,736	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	517,645	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	64,238,613			2,438,454	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
56.01	03630	ULTRA SOUND	0	0	0		56.01
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0	0		69.01
69.02	03650	VASCULAR LAB	0	0	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	03480	ONCOLOGY	0	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.358340	0	3,299,433	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.139360	0	617,730	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.448551	0	1,167,190	0	0	54.00
56.00	05600	RADIOISOTOPE	0.448657	0	405,091	0	0	56.00
56.01	03630	ULTRA SOUND	0.197435	0	261,721	0	0	56.01
57.00	05700	CT SCAN	0.070130	0	2,911,587	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.304579	0	820,700	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.184628	0	4,957,544	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.427729	0	52,374	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.196390	0	581,425	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.647411	0	539,139	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663824	0	72,588	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.698868	0	24,614	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.280516	0	712,616	0	0	69.01
69.02	03650	VASCULAR LAB	0.406286	0	370,166	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.855317	0	38,518	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.542403	0	650,060	13,413	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.358104	0	2,286,685	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.966628	0	257,571	0	0	92.00
200.00		Subtotal (see instructions)		0	20,026,752	13,413	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	20,026,752	13,413	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,182,319	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	86,087	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	523,544	0		54.00
56.00	05600	RADIOISOTOPE	181,747	0		56.00
56.01	03630	ULTRA SOUND	51,673	0		56.01
57.00	05700	CT SCAN	204,190	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	249,968	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	915,301	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	22,402	0		62.00
65.00	06500	RESPIRATORY THERAPY	114,186	0		65.00
66.00	06600	PHYSICAL THERAPY	349,045	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	48,186	0		67.00
68.00	06800	SPEECH PATHOLOGY	41,816	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	199,900	0		69.01
69.02	03650	VASCULAR LAB	150,393	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,945	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	352,594	7,275		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	818,871	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	506,546	0		92.00
200.00		Subtotal (see instructions)	6,031,713	7,275		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,031,713	7,275		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141325 | Component CCN: 14Z325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.358340	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.139360	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.448551	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.448657	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0.197435	0	0	0	0	56.01
57.00	05700	CT SCAN	0.070130	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.304579	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.184628	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.427729	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.196390	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.647411	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663824	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.698868	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.280516	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0.406286	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.855317	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.542403	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.358104	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.966628	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141325 | Component CCN: 14Z325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	03630	ULTRA SOUND	0	0		56.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
69.02	03650	VASCULAR LAB	0	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,042	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,680	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,205	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	316	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	46	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	847	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	316	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	144.08	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	144.08	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,284,427	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	6,628	25.00
26.00	Total swing-bed cost (see instructions)	683,876	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,600,551	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,600,551	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,143.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,815,282	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,815,282	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	278,867	58	4,808.05	42	201,938	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	757,601	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,774,821	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	677,248	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	677,248	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	475	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,143.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,018,015	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	546,110	3,600,551	0.151674	1,018,015	154,406	90.00
91.00	Nursing School cost	0	3,600,551	0.000000	1,018,015	0	91.00
92.00	Allied health cost	0	3,600,551	0.000000	1,018,015	0	92.00
93.00	All other Medical Education	0	3,600,551	0.000000	1,018,015	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,232,788		30.00
31.00	03100	INTENSIVE CARE UNIT		137,701		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.358340	249,325	89,343	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.139360	87,486	12,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.448551	61,464	27,570	54.00
56.00	05600	RADIOISOTOPE	0.448657	16,982	7,619	56.00
56.01	03630	ULTRA SOUND	0.197435	14,809	2,924	56.01
57.00	05700	CT SCAN	0.070130	60,419	4,237	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.304579	20,289	6,180	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.184628	502,665	92,806	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.427729	23,297	9,965	62.00
65.00	06500	RESPIRATORY THERAPY	0.196390	802,186	157,541	65.00
66.00	06600	PHYSICAL THERAPY	0.647411	118,446	76,683	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663824	62,244	41,319	67.00
68.00	06800	SPEECH PATHOLOGY	1.698868	8,676	14,739	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.280516	26,609	7,464	69.01
69.02	03650	VASCULAR LAB	0.406286	7,517	3,054	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.855317	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.542403	376,040	203,965	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.358104	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.966628	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,438,454	757,601	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,438,454		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3

Component CCN: 14Z325 | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.358340	1,014	363	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.139360	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.448551	4,801	2,153	54.00
56.00	05600	RADIOISOTOPE	0.448657	0	0	56.00
56.01	03630	ULTRA SOUND	0.197435	752	148	56.01
57.00	05700	CT SCAN	0.070130	1,800	126	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.304579	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.184628	46,510	8,587	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.427729	367	157	62.00
65.00	06500	RESPIRATORY THERAPY	0.196390	87,000	17,086	65.00
66.00	06600	PHYSICAL THERAPY	0.647411	123,649	80,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663824	95,234	63,219	67.00
68.00	06800	SPEECH PATHOLOGY	1.698868	495	841	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.280516	1,100	309	69.01
69.02	03650	VASCULAR LAB	0.406286	3,505	1,424	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.855317	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.542403	85,871	46,577	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.358104	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.966628	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		452,098	221,042	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		452,098		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141325	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/25/2016 9:53 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,038,988	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,038,988	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6,099,378	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	31,062	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,999,312	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,069,004	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,069,004	30.00
31.00	Primary payer payments	276	31.00
32.00	Subtotal (line 30 minus line 31)	3,068,728	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	685,582	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	445,628	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	582,633	36.00
37.00	Subtotal (see instructions)	3,514,356	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,514,356	40.00
40.01	Sequestration adjustment (see instructions)	70,287	40.01
41.00	Interim payments	3,350,688	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	93,381	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,956,503		4,703,321	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	04/30/2015	410,361		0	3.01
3.02		09/28/2015	122,412		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/28/2015	419,644	09/28/2015	1,352,633	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		113,129		-1,352,633	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,069,632		3,350,688	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		411,923		93,381	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,481,555		3,444,069	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141325 | Component CCN: 14Z325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		687,333		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/28/2015	49,311		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		49,311		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		736,644		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		152,483		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		889,127		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141325	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/25/2016 9:53 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	476	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	889	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	72	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,263	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	65,963,039	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,329,451	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	63,906	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	62,404	8.00
9.00	Sequestration adjustment amount (see instructions)	1,248	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	61,156	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	61,156	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141325 Component CCN: 14Z325	Period: From 10/01/2014 To 09/30/2015	Worksheet E-2 Date/Time Prepared: 2/25/2016 9:53 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	684,020	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	223,252	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	316	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	907,272	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	907,272	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	907,272	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	907,272	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	907,272	0	19.00
19.01	Sequestration adjustment (see instructions)	18,145	0	19.01
20.00	Interim payments	736,644	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	152,483	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141325	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/25/2016 9:53 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,774,821	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,774,821	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,802,569	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,802,569	19.00
20.00	Deductibles (exclude professional component)	305,488	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,497,081	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,497,081	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	54,027	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	35,118	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	51,478	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,532,199	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,532,199	30.00
30.01	Sequestration adjustment (see instructions)	50,644	30.01
31.00	Interim payments	2,069,632	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	411,923	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	286,922	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/25/2016 9:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	9,452,654	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,546,224	0	0	0	4.00
5.00	Other receivable	207,100	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	368,383	0	0	0	7.00
8.00	Prepaid expenses	319,179	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	540,292	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,433,832	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	588,318	0	0	0	12.00
13.00	Land improvements	854,467	0	0	0	13.00
14.00	Accumulated depreciation	476,896	0	0	0	14.00
15.00	Buildings	20,224,022	0	0	0	15.00
16.00	Accumulated depreciation	-17,051,439	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	23,610,241	0	0	0	23.00
24.00	Accumulated depreciation	-15,318,854	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	104,374	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,488,025	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,356,835	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	747,364	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,104,199	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,026,056	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,968,398	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,259,975	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,738,333	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,966,706	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	27,027	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	27,027	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	5,993,733	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	26,032,323				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	26,032,323	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,026,056	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/25/2016 9:53 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,966,792		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,065,531				2.00
3.00	Total (sum of line 1 and line 2)		26,032,323		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		26,032,323		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		26,032,323		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2016 9:53 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,155,539		1,155,539	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	315,544		315,544	5.00
6.00	Swing bed - NF	45,934		45,934	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,517,017		1,517,017	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	209,500		209,500	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	209,500		209,500	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,726,517		1,726,517	17.00
18.00	Ancillary services	4,473,159	48,106,811	52,579,970	18.00
19.00	Outpatient services	282,705	8,633,585	8,916,290	19.00
20.00	RURAL HEALTH CLINIC	0	2,740,262	2,740,262	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL REVENUES	569,344	7,539,118	8,108,462	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,051,725	67,019,776	74,071,501	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,447,584		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,447,584		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141325 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/25/2016 9:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,071,501	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,134,607	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,936,894	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,447,584	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,489,310	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	60,981	6.00
7.00	Income from investments	1,129,975	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	130,071	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	6,191	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	171,386	24.00
24.01	GAIN ON DISPOSAL OF ASSETS	77,617	24.01
25.00	Total other income (sum of lines 6-24)	1,576,221	25.00
26.00	Total (line 5 plus line 25)	3,065,531	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,065,531	29.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 141325 Component CCN: 143445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/25/2016 9:53 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	575,058	340,845	915,903	-407,857	508,046	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	418,261	0	418,261	0	418,261	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	333,438	0	333,438	0	333,438	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	25,000	0	25,000	0	25,000	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,351,757	340,845	1,692,602	-407,857	1,284,745	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	40,820	40,820	0	40,820	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	40,820	40,820	0	40,820	14.00
15.00	Medical Supplies	0	15,607	15,607	0	15,607	15.00
16.00	Transportation (Health Care Staff)	0	17,733	17,733	0	17,733	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	28,613	28,613	0	28,613	18.00
19.00	Other Health Care Costs	0	24,462	24,462	0	24,462	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	86,415	86,415	0	86,415	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,351,757	468,080	1,819,837	-407,857	1,411,980	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	255,629	12,928	268,557	0	268,557	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	255,629	12,928	268,557	0	268,557	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,607,386	481,008	2,088,394	-407,857	1,680,537	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 141325 | Component CCN: 143445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/25/2016 9:53 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	508,046		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	418,261		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	333,438		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	25,000		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,284,745		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	40,820		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	40,820		14.00
15.00	Medical Supplies	0	15,607		15.00
16.00	Transportation (Health Care Staff)	0	17,733		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	28,613		18.00
19.00	Other Health Care Costs	-4,249	20,213		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	-4,249	82,166		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-4,249	1,407,731		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	268,557		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	268,557		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,249	1,676,288		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141325 | Component CCN: 143445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/25/2016 9:53 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.04	3,635	4,200	4,368		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.88	9,749	2,100	8,148		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.92	13,384		12,516	13,384	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.40	39			39	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.32	13,423			13,423	8.00
9.00	Physician Services Under Agreements		427			427	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,407,731	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,407,731	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					268,557	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,635,003	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,903,560	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					1,903,560	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,903,560	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					3,311,291	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 2/25/2016 9:53 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		3,311,291	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		37,931	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,273,360	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		13,423	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		427	5.00
6.00	Total adjusted visits (line 4 plus line 5)		13,850	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		236.34	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	236.34	236.34	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	479	1,436	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	113,207	339,384	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		452,591	16.00
16.01	Total program charges (see instructions)(from contractor's records)		266,107	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		12,459	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		21,190	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		332,032	16.04
16.05	Total program cost (see instructions)		353,222	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,361	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		47,457	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		353,222	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,989	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		361,211	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		361,211	26.00
26.01	Sequestration adjustment (see instructions)		7,224	26.01
27.00	Interim payments		298,142	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		55,845	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141325 | Component CCN: 143445 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-4 | Date/Time Prepared: 2/25/2016 9:53 am

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,284,745	1,284,745	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001540	0.001132	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,979	1,454	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,522	8,170	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,501	9,624	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,407,731	1,407,731	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1,903,560	1,903,560	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004618	0.006837	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	8,791	13,015	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	15,292	22,639	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	68	499	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	224.88	45.37	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	21	72	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,722	3,267	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		37,931	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		7,989	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141325 Component CCN: 143445

Period: From 10/01/2014 To 09/30/2015

Worksheet M-5

Date/Time Prepared: 2/25/2016 9:53 am

Rural Health Clinic (RHC) I

Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		302,348	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		04/30/2015	33,788	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		05/28/2015	31,955	3.50
3.51		09/28/2015	6,039	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-4,206	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		298,142	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		55,845	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		353,987	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00